It's Your Choice 2015

Wisconsin Public Employers
Group Health Insurance Program
(Local Government Employees and Annuitants)

Form Number: 15ET-2128faq

Frequently Asked Questions

Below is detailed information regarding enrollment and plan change opportunities during and beyond the annual It's Your Choice Open Enrollment period, dependent eligibility, benefits and services, Medicare and termination of coverage.

Questions previously listed in the *It's Your Choice Decision* and *Reference Guides* are compiled here. This information is intended to provide understandable explanations of technical provisions of the Uniform Benefits Certificate of Coverage. In the event of any conflict between the terms of the Uniform Benefits Certificate of Coverage and the information contained in the Frequently Asked Questions section, the terms of the Certificate of Coverage shall control.

Question Topics

General Information

General Information

1. Who is eligible for Wisconsin Public Employers Group Health Insurance Program?

Information about the Wisconsin Public Employers Group Health Insurance Program in this guide applies to the following individuals whose employer has elected this coverage:

- Active employees participating in the Wisconsin Retirement System.
- Retired employees who receive an annuity from the WRS (including a lump sum or disability annuity) and who were participants in the employer's previous group health plan.
- Insured employees who terminate employment after age 55 (age 50 for protectives) and who have 20 years of creditable service.
- The surviving insured spouse of an insured employee or an insured retiree.
- Employees of a Wisconsin Public Employer who do not participate in the WRS and who is a separate Social Security entity.

2. What is the health insurance marketplace and is it an option for me?

The Marketplace, established under the Patient Protection and Affordable Care Act (PPACA), allows individuals to shop for health insurance outside of our program. This may be of interest to annuitants who are paying premiums out-of-pocket. Note, premiums for Marketplace insurance cannot be paid out of sick leave credits or with any employer contribution. After evaluating the benefit levels of the Marketplace, it has been found that only platinum level plans are considered comparable coverage for the purposes of escrowing accumulated sick leave conversion credits. Visit healthcare.gov for more information.

Insurance Complaint Process

3. What if I have a complaint about my health plan or Pharmacy Benefit Manager?

Each of the plans participating in the Wisconsin Public Employers Group Health Insurance Program is required to have a complaint and grievance resolution procedure in place to help resolve participants' problems. Your plan has information on how to initiate this process. You must exhaust all of your appeal rights through the plan first in order to pursue review through an Independent Review Organization (IRO) or through ETF and the Group Insurance Board. If the plan upholds its denial, it will state in its final decision letter your options if you wish to proceed further.

4. What if my health plan upholds a denial that is based on medical reasons, such as "medical necessity?"

Depending on the nature of your complaint, you may be given rights to request an independent review through an outside organization approved by the Office of the Commissioner of Insurance. This option becomes available when a plan has denied services as either not medically necessary or experimental, or due to a preexisting condition exclusion denial or rescission of coverage. *Note*: If you choose to have an independent review organization (IRO) review the plan's decision, that decision is binding on both you and your plan except for any decision regarding a preexisting condition exclusion denial or the rescission of coverage. Apart from these two exceptions, you have no further rights to a review through the ETF or the courts once the IRO decision is rendered.

5. What if my health plan upholds a denial that is not eligible for IRO, such as a denial based on contract interpretation?

As a member of the Wisconsin Public Employers Group Health Insurance Program, you have the right to request an administrative review through ETF if your health plan has rendered a decision on your grievance and it is not eligible for IRO review as described above. To initiate an ETF review, you may call or send a letter to ETF and request an *Employee Trust Funds Complaint Form* (ET-2405). Complete the complaint form and attach all pertinent documentation, including the plan's response to your grievance.

Please note that ETF's review will not be initiated until you have completed the grievance process available to you through the plan. After your complaint is received, it is acknowledged and information is obtained from the plan. An ETF ombudsperson will review and investigate your complaint and attempt to resolve your dispute with your plan. If the ombudsperson is unable to resolve your complaint to your satisfaction, you will be notified of additional administrative review rights available through ETF.

Tax Implications

6. What are the tax implications for covering non-tax dependents?

Domestic Partners: The fair market value for insurance coverage provided for a domestic partner and his or her children must be calculated and added to your income, unless the domestic partner and his or her children qualify as your tax dependents.

The fair market value of the health insurance benefits will be calculated and added to your earnings as imputed income. The monthly imputed income amounts vary by health plan and are provided for either one non-tax dependent, or two or more nontax dependents. These dollar amounts will be adjusted annually and are available from your employer. Annuitants who have family coverage may cover non-tax dependents. If the premium is paid directly by the annuitant or through annuity deduction, there will be no imputed income on the value of the non-tax dependent's coverage. However, if the premium is being paid using accumulated sick leave conversion credits, the value of the non-tax dependent's coverage will be added to the annuitant's earnings as imputed income on a W-2 from ETF in January.

Employees who are unsure if a person can be claimed as a dependent should consult IRS Publication 501 or a tax advisor.

Employees may change from single to family coverage to add a newly eligible domestic partner or other dependent who does not qualify as a tax dependent under Internal Revenue Code Section 152 during the plan year. The additional premium attributable to the non-qualified dependent will be taxable.

Adult Children: The Patient Protection and Affordable Care Act (PPACA) and 2011 Wisconsin Act 49 eliminated tax liability for the fair market value of health coverage for these dependents through the month in which they turn 26, if eligible.

If the tax dependent status of your dependent over age 26 changes, please notify your employer (or for annuitants and continuants, ETF).

7. What is imputed income?

Imputed income is the non-cash benefit earned for items (e.g., health insurance for certain dependents) that is reported as income to the government on the W-2 and other forms. Employees and annuitants may be taxed on the fair market value of the health care coverage extended to their dependents who do not qualify as dependents for tax purposes.

See Question: What are the tax implications for covering non-tax dependents? to learn when imputed income applies. For more information, employees should contact their employer; annuitants should contact ETF.

Enrolling For Coverage

Selecting a Health Plan

1. Can family members covered under one policy choose different health plans?

No, family members are limited to the plan selected by the subscriber.

2. Can I receive medical care outside of my health plan network?

This can be a concern for members who travel and those with covered dependents living elsewhere, such as a college student living away from home. Consider the following when selecting a health plan: If you are covered through an HMO, you are required to obtain allowable care only from providers in the HMO's network.

HMOs will cover emergency care outside of their service areas, but you must get any follow-up care to the emergency from providers in the HMO's network. Do not expect to join an HMO and get a referral to a non-HMO physician. An HMO generally refers outside its network only if it is unable to provide needed care within the HMO.

If you are covered through a Preferred Provider Organization (PPO) such as WEA Trust or the Standard Plan, you have the flexibility to seek care outside a particular service area. However, out-of-network care is subject
to higher deductible and coinsurance amounts.

Annuitants only: If you or your dependents are covered through the Medicare Plus plan, you have the freedom of choice to see any available provider for covered services.

In addition, Humana's Medicare Advantage-PPO offers coverage for participants with Medicare Parts A and B, with both in- and out-of-network benefits. Note: Non-Medicare members are limited to Humana's HMO network.

3. How can I get a listing of the physicians participating in each plan?

Contact the plan directly or follow the instructions provided in the Health Plan Descriptions section of the It's Your Choice 2015 Decision Guide. ETF and your benefits/payroll/personnel office do not have this information.

4. What steps should I follow to enroll in the health insurance program?

- Determine which plans have providers in your area.
- Contact the health plans directly for information regarding available physicians, medical facilities and services. If your health plan offers dental and has a third party administrator for your dental benefits (such as Delta Dental), you must contact the dental administrator directly for information regarding benefits and available dental providers.
- Review the health plan rates, report card information and the plan descriptions located in the *It's Your Choice Decision Guide*.
- File an application online at http://myETF.wi.gov/ONM.html by selecting "myETF

Benefits" and following the quick and easy instructions, unless otherwise instructed by your employer, or by submitting a paper *Group Health Insurance Application/Change Form* (ET-2301). Employees should file with their benefits/payroll/personnel office within the required enrollment period. Annuitants and continuants should file their application with ETF.

New Employee Enrollment

5. When does my coverage go into effect as a new employee?

If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for preexisting medical conditions, provided you file an electronic or paper health application with your benefits/payroll/personnel office within the required enrollment period stated below:

1. Within 30 days of your date of hire in an eligible position. Coverage will be effective the first day of the month on or following receipt of the application by your employer either electronically or via paper, or
2. Within 30 days prior to the date that the employer contributes to the premium, with coverage becoming effective when you become eligible for employer contribution.

There are no interim effective dates except as required by law. However, you may enroll for single coverage within 30 days of your date of hire and change to family coverage if your electronic or paper application is received prior to the date the employer contributions begin.

If you cancel your policy prior to the date that the employer contribution starts, you may re-enroll in health insurance with the new coverage becoming effective on the first day of the month that employer contribution begins.

You cannot assume that the month when your first payroll deduction occurs is the month when your coverage begins. Health premiums are deducted in advance of coverage. For further information on deductions, coverage and effective dates, contact your benefits/payroll/personnel office.

Important Information for Less Than Half-Time Employees:

The initial enrollment opportunity for most employees begins with their participation in the WRS. However, if you are a less than half-time employee, you have another enrollment period if:

1. There has been a 30-day termination of employment break; or
2. Your hours of employment increase due to a change in your appointment and you qualify for a higher share of employer contribution toward health insurance premiums; or
3. You are appointed to a permanent position and now qualify for the full share of employer contribution.

If you apply for coverage within 30 days of one of these events, coverage will be effective on the later of the first of the month following the employer's receipt of the application, either electronically or via paper, or the effective date of the increase in the employer contribution. Retroactive effective dates are not allowed. This does not provide an opportunity to change from single to family coverage.

You may also enroll during the annual It's Your Choice Open Enrollment period for coverage to be effective January 1 of the following year.

Other Enrollment Opportunities

6. Are there other enrollment opportunities available to me after my initial one expires?

You may be able to get health insurance coverage if you are otherwise eligible under specific circumstances as described below:

- If you are an active employee and you and/or your dependent(s) are not insured under the Wisconsin Public Employers Group Health Insurance Program because of being insured under a group health insurance plan elsewhere, you may take advantage of a special 30-day enrollment period to become insured in this program without waiting periods for preexisting conditions if:

1. Your eligibility for that other coverage is lost or the employer's premium contribution for the other plan ends, or
2. You and/or your dependents lose medical coverage:
    - Under medical assistance (Medicaid); or
    - Upon return from active military service with the armed forces. Employees must return to employment within 180 days of release from active duty. You are entitled to enroll regardless of the coverage in effect. Coverage is effective on the date of your re-employment, or
    - As a citizen of a country with national health care coverage comparable to the Standard Plan.

The enrollment period begins on the date the other group health insurance coverage terminates because of loss of eligibility (for example, termination of employment, divorce, etc., but not voluntary cancellation of coverage) or the employer's premium contribution ends.

- If you are currently enrolled in the Wisconsin Public Employers Group Health Insurance Program with single coverage, because your dependents are insured under a group health insurance plan elsewhere, and eligibility for that coverage is lost or the employer's premium contribution for the other plan ends, you may take advantage of a special 30-day enrollment period to change from single to family coverage without waiting periods for preexisting conditions. Coverage will be effective on the date the other coverage or the employer's premium contribution ends.
- If you are currently enrolled in the Wisconsin Public Employers Group Health Insurance Program with family coverage, you may request to provide coverage for your eligible adult child who is not currently insured. You do this during the It's Your Choice Open Enrollment period. Coverage for your child will be effective the following January 1.
- If you are not insured under the Wisconsin Public Employers Group Health Insurance Program and have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption, you may enroll if coverage is elected within 30 days of marriage or effective date of the domestic partnership, or 60 days of the other events. Coverage is effective on the date of marriage, birth, adoption or placement for adoption. Domestic partnership coverage is effective the date ETF receives the completed *Affidavit of Domestic Partnership* (ET-2371).
- If you and/or your dependents lose medical coverage under the Children's Health Insurance Program (CHIP) or become eligible to participate in a premium assistance program, you will have an opportunity to enroll in the Wisconsin Public Employers Group Health Insurance Program without waiting periods for preexisting conditions by filing an

application either electronically or via paper within 60 days of the loss of eligibility or the date you become eligible for premium assistance and by providing evidence satisfactory to ETF.
- If you do not enroll during a designated enrollment period, you may enroll for health insurance coverage, if you are otherwise eligible, during the annual It's Your Choice Open Enrollment period.

Open Enrollment

The It's Your Choice Open Enrollment period is the annual opportunity for eligible employees to select one of the many health plans offered by the Wisconsin Public Employers Group Health Insurance Program. The following list contains some of the most commonly asked questions about the enrollment period. You can also find information about key terms in the definitions section of the *It's Your Choice 2015 Reference Guide.*

7. What is the It's Your Choice Open Enrollment period?

The It's Your Choice Open Enrollment period is an opportunity to change plans, change from family to single coverage, enroll if you had previously deferred coverage, cancel your coverage or cancel the coverage for your adult dependent child. It is offered only to employees, annuitants and surviving spouses and dependents who are eligible under the Wisconsin Public Employers Group Health Insurance Program. Changes made become effective January first of the following year.

8. May I change from single to family coverage during the It's Your Choice Open Enrollment period?

Yes, you have the opportunity to change from single to family coverage without a waiting period or exclusions for preexisting medical conditions. Coverage will be effective January 1 of the following year for all eligible dependents. Note that if you are subject to tax liability for dependents such as adult children, and/or a domestic partner and his or her child(ren), you can elect not to cover such individuals. For information about the tax impact of covering non-tax dependents, see Question: Are there other enrollment opportunities available to me after my initial one expires?

Making Changes During It's Your Choice Open Enrollment

9. How do I change health plans during It's Your Choice Open Enrollment?

If you decide to change to a different plan, you are encouraged to make changes online using the myETF Benefits website (see Pages 5 through 8 of the *It's Your Choice 2015 Decision Guide*), or you may submit a paper application using the following instructions:
Active employees** may use the application in the back of this guide, get our form (et-2301) or receive paper applications from your benefits/payroll/personnel office to complete and return to that office. Applications received after the deadline will not be accepted.

Note: If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action.

10. How do I use the myETF Benefits website?

Refer to the myETF Benefits System Instructions section of the *It's Your Choice 2015 Decision Guide*.

11. What happens if I enter my changes online, but did not submit them?

Your changes will not be stored unless you click on the Submit button. You will need to log back in and make the changes again. To view what you submitted, click the myRequests button on the bottom of the myInfo page.

12. What is the effective date of changes made during the It's Your Choice Open Enrollment period?

It's Your Choice coverage changes are effective January 1 of the following year.

13. What if I change my mind about the health plan I selected during the It's Your Choice Open Enrollment period?

You may submit or make changes anytime during the It's Your Choice Open Enrollment period by filling out a paper application. After that time, you may rescind, that is, withdraw your application (and keep your current coverage) by following these instructions before December 31:

• active employees should inform their benefits/payroll/personnel office.

Other rules apply when canceling coverage. For more information, see the Cancellation or Termination of Coverage section.

14. Which other changes can be made during the It's Your Choice Open Enrollment period if my health insurance premiums are taken pre-tax?

During the annual enrollment period, you can add or drop coverage for yourself and/or your adult dependent children or do a spouse/domestic partner to spouse/domestic partner transfer of your health insurance coverage.

Changes in Employment Status

Employees

1. How are my health benefits affected by changes in employment status?

Layoff/Leave of Absence
Continuation of Coverage: Coverage may be continued for up to three years while you remain in employee status but receive no salary (limited to layoff or approved leave of absence). Arrangements for premium payment must be made with your personnel or payroll office prior to the time the layoff/leave of absence begins. A leave of absence is not considered ended until you have terminated employment or have resumed employment for at least 50% of what is considered your normal work time for that employer for 30 consecutive calendar days. If coverage is not continued during layoff/leave of absence, there are no continuation rights if employment terminates.

Reinstatement of Coverage: If your health coverage lapses during your leave or layoff due to non-payment of premiums, you must submit a new application either electronically or via paper within 30 days of returning to payroll to reinstate the lapsed coverage. Coverage will be effective the first of the month after the application is received by your payroll office. If an It's Your Choice Open Enrollment period has occurred while you were on leave, you will be offered an enrollment opportunity upon your return. (See Question: Are there other enrollment opportunities available to me after my initial one expires?)

Lapsed coverage can also be reinstated for an employee who has been on a leave of absence, who is entitled to and applies for an immediate annuity. Coverage shall be effective the first day of the calendar month that occurs on or after the date the annuity application is approved by ETF, provided an application for health insurance has been received by that date either electronically or via paper.

If you occupy a seasonal or teaching position and do not receive pay between the end of one term of service and the beginning of another, your coverage may continue if you authorize a payroll deduction before your earnings are interrupted or make other provisions to pay premiums in advance.

Termination of Employment
Coverage will end on the last day for which premiums are paid. (See Continuation of Health Coverage)

Appealing a Discharge
Coverage may be continued if you have been terminated from employment and are appealing discharge. The first premium payment and the appeal must both be filed within 30 days of discharge. Premium payments must be made through your employer and be received at least 30 days prior to the end of the period for which premiums were previously paid. You must pay the gross amount of premium due until the appeal is resolved. If the appeal is resolved in your favor, the amount normally considered the employer contribution will be refunded to you.

Retirement
If your employer offers post-retirement health insurance payments and you are an employee who deferred coverage, you may enroll for coverage in the Standard Plan immediately prior to retirement in order to use post-retirement employer premium contribution.

If you are covered when you retire, the health benefit plan will automatically continue if your

retirement annuity from the WRS begins within 30 days after employment ends. If you are eligible for Medicare, effective dates must be provided before coverage continues. (Those eligible for Medicare and enrolled in the Standard Plan or SMP will be switched to Medicare Plus.) You must fill out the employer verification form and return it with your retirement application.

Note: If you are eligible for Medicare, you must be enrolled in the hospital (Part A) *and* medical (Part B) portions of Medicare at the time of your retirement. Enrollment in the prescription drug portion (Part D) is voluntary.

Medicare enrolled retirees will be enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified Medicare-contracting prescription drug plan. This is Medicare Part D coverage through an Employer Group Waiver Plan (EGWP) administered by Navitus" Health Solutions, the Wisconsin Public Employers group health insurance program's pharmacy benefit manager. This replaces the current Medicare Part D prescription drug plan provided by DeanCare Rx. Supplemental wrap coverage is also included to ensure your prescription drugs are covered when you reach the Medicare Part D coverage gap, commonly referred to as the "donut hole." Please see the Medicare Information section in the *Frequently Asked Questions* for additional information. Also see the Navitus plan description pages in the *It's Your Choice Decision Guide* for more detailed information.

If you do not enroll for all available portions of Medicare (A, B and D) upon retirement, you may be liable for the portion of your claims that Medicare would have paid on the date Medicare coverage would have become effective. (See the Medicare Information provided later in this section.)

Premium rates for retired employees are the same as for the active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). The employer may, at its option, pay all or a portion of the premium. If any portion of the premium is employer paid, you must remit your portion of the premium directly to the former employer. If/when your employer does not pay any portion of the premium, the premium will be deducted from your monthly annuity. If the annuity is not sufficient to allow a premium deduction, you will be billed directly.

Re-Employed Annuitants

2. How are my health benefits affected if I return to work for an employer not under the WRS?

If you return to work for a non-WRS participating employer after retirement, your WRS annuity and health benefits will not be affected.

3. How are my health benefits and premiums affected if I return to work for an employer who is under the WRS?

If you return to work for a WRS-participating employer, you may be eligible to once again become an active WRS employee. If you make this election and become an active WRS employee, your annuity will be cancelled and you will no longer be eligible for health insurance as a retiree/annuitant. You will be eligible for health insurance as an active WRS employee through your WRS-participating employer if the employer is participating in an ETF health

plan. Check with your employer to make sure you have other health insurance coverage available before you elect WRS participation.

You may also waive or terminate enrollment under Medicare until the first Medicare enrollment period after active WRS employment ceases. Your premium rates while covered through active employment will be the active employee rates shown in the *It's Your Choice Decision Guide*, not the Medicare rates.

When you subsequently terminate employment and resume your annuity, your eligibility for Wisconsin Public Employers Group Health Insurance Program coverage is once again dependent on you meeting the requirements for newly retired employees (that is, you must be insured under the Wisconsin Public Employers Group Health Insurance Program, and you must apply for an immediate annuity from the WRS).

Dependent Information

Single coverage covers only you. Family coverage covers those described below. All eligible, listed dependents are covered under a family contract. A subscriber cannot choose to exclude any other eligible dependent from family coverage except as described in the question: When does health coverage terminate for my dependents?

Dependent Eligibility

1. Who is eligible as a dependent if I select family coverage?

- Your spouse.
- Your domestic partner if elected.
- Your children who include:
  1. Your natural children.
  2. Stepchildren or children of your domestic partner insured on the policy.
  3. Adopted children and pre-adoption placements. Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or on the date the child is placed in the custody of the subscriber, whichever occurs first. These dates are defined by Wis. Stat. § 632.896. If the adoption of a child is not finalized, the insurer may terminate coverage of the child when the adoptive placement ends.
  4. Legal wards that become your permanent ward before age 19. Coverage will be effective on the date that a court awards permanent guardianship to you (the subscriber or your spouse or domestic partner).

  Note: Children may be covered until the end of the month in which they turn 26. His/her spouse and dependents are not eligible. Upon losing eligibility, they may be eligible for COBRA continuation. (See Question:Who is eligible for continuation?) Coverage may continue beyond that when children:

  1. Have a disability of long standing duration, are unmarried, dependent on you or the other parent for at least 50% of support and maintenance and are incapable of self-support; or
  2. Are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education. Note: The adult child must apply to an institution of higher education as a full-time student within 12 months from the date the adult child fulfilled his or her active duty obligation.
- Your grandchildren born to your insured dependent children may be covered until the end of the month in which your insured dependent (your grandchild's parent) turns age 18. Your child's eligibility as a dependent is unaffected by the birth of the grandchild.

  Important note: There are state and/or federal tax consequences to you when you provide coverage for dependents that do not meet the support test for federal income tax purposes. An example of such a dependent is a domestic partner who is not dependent on you for at least 50% of their support and maintenance.

2. What if my spouse/domestic partner and I work for the same employer?

Your employer may determine whether married employees or domestic partners may each elect single or family coverage or if they are eligible only for family coverage through one of the spouses or domestic partners.

3. What are my coverage options if my spouse/domestic partner is also a state of Wisconsin or participating Wisconsin Public Employer (WPE) employee or state annuitant?

Note: If you are an annuitant and cancel your health insurance coverage, you will not be able to re-enroll in this program.

- If your spouse/domestic partner is an eligible state employee or annuitant, you may each elect single coverage with your current plan(s) if you have no other eligible dependents; or one or both of you may select family coverage that will cover all of your eligible dependents.
- If both spouses or domestic partners are each enrolled for single coverage and premiums are being deducted on a pre-tax basis, family coverage may only be elected effective at the beginning of the calendar year or when the employees have gained a dependent that necessitates family coverage.
- If premiums are being deducted on a post-tax basis, one of the single contracts may be changed to a family plan at anytime without restriction and the other single contract will be cancelled (see "Note" above). Family coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application.
- If premiums for family coverage are being deducted on a pre-tax basis, coverage may only be changed to single coverage effective at the beginning of the calendar year or when the last dependent becomes ineligible for coverage, or becomes eligible for and enrolled in other group coverage.
- If premiums are being deducted post-tax, one family policy can be split into two single plans with the same carrier effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application from both spouses or domestic partners.

  Note: A subscriber who has family coverage that covers only a domestic partner and/or other non-tax dependents such as a domestic partner's children can change to single coverage at anytime. This is because the non-tax dependent's coverage is taxed as imputed income and not subject to the federal regulations governing pre-tax deductions.

Some things to note:

1. If you and your spouse/domestic partner each have single coverage, no dependents are covered and if he or she should die, that individual's sick leave credits are not available for your use. Under a state of Wisconsin family plan, sick leave credits are preserved for the surviving dependents regardless of who should die first. If your employer offers post-retirement benefits, discuss the program's options with your payroll/benefits/personnel office.
2. If you or your spouse/domestic partner have family coverage and want to change the named subscriber for the family coverage to the other spouse/domestic partner and the coverage is being deducted on a pre-tax basis, coverage may only be changed to the other spouse/domestic partner:
   - effective at the beginning of the calendar year;
   - when the subscriber carrying the coverage terminates employment or goes on an

unpaid leave of absence;or
- the premium contribution increases because of reduced work hours.

For subscribers whose premiums are being deducted on a post-tax basis, coverage can be changed at anytime.

Coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application. (Note: WPE annuitants who terminate their coverage may not re-enroll).

3. If at the time of marriage, the employees and/or annuitants each have family coverage or one has family coverage and the other has single coverage, coverage must be changed to one of the options listed above within 30 days of marriage to be effective as of the date of marriage (unless you both work for the same WPE that allows double coverage). Failure to comply with this requirement may result in denial of claims for eligible dependents. Note: Change from single to family coverage due to marriage is effective the date of marriage if an electronic or paper application is received by your employer (or for annuitants/continuants by ETF) within 30 days of the marriage.
4. If at the time a domestic partnership is formed (effective on the date that ETF receives a completed *Affidavit of Domestic Partnership* (ET-2371)), and the employees and/or annuitants each have family coverage, or one has family coverage and the other has single coverage, coverage must be changed to one of the options listed above within 30 days of the effective date (unless you both work for the same WPE that allows double coverage). Failure to comply with this requirement may result in denial of claims for eligible dependents. Note: A copy of the Affidavit of Domestic Partnership (ET-2371) and an electronic or paper application must be received by your employer (or for annuitants/continuants by ETF) within 30 days of the beginning of the domestic partnership. Further information is available at etf.wi.gov.

4. What if I have a child who is, or who becomes, physically or mentally disabled?

If your unmarried child has a physical or mental disability that is expected to be of long-continued or indefinite duration and is incapable of self-support, he or she may be eligible to be covered under your health insurance through our program.

You must work with your health plan to determine if your child meets the disabled dependent eligibility criteria. If disabled dependent status is approved by the plan, you will be contacted annually to verify the adult dependent's continued eligibility.

If your child loses eligibility for coverage due to age or loss of student status, but you are now indicating that the child meets the disabled dependent definition, eligibility as a disabled dependent must be established before coverage can be continued. If you are providing at least 50% support, you must file an electronic or paper application with your employer to initiate the disability review process by the health plan. Your dependent will be offered COBRA continuation*.

If your disabled dependent child, who has been covered due to disability, is determined by the health plan to no longer meet their disability criteria, the plan will notify you in writing of their decision. They will inform you of the effective date of cancellation, usually the first of the month following notification, and your dependent will be offered COBRA continuation*. If you would like to appeal the plan's decision, you must first complete the plan's grievance procedure. If the plan continues to deny disabled dependent status for your child, you may appeal the plan's grievance decision to ETF by filing an *ETF Insurance Complaint Form* (ET-2405). *Note*: If you

are changing health plans, see also the Changing Health Plans section.

* Electing COBRA continuation coverage should be considered while his or her eligibility is being verified. If it is determined that the individual is not eligible as a disabled dependent, there will not be another opportunity to elect COBRA. If it is later determined that the child was eligible for coverage as a disabled dependent, coverage will be retroactive to the date they were last covered, and premiums paid for COBRA continuation coverage will be refunded.

5. What if I don't have custody of my children?

Even though custody of your children may have been transferred to the other parent, you may still insure the children if the other dependency requirements are met.

6. When does health coverage terminate for my dependents?

Coverage for dependent children who are not physically or mentally disabled terminates on the earliest of the following dates:

- The date eligibility for coverage ends for the subscriber.
- The end of the month in which:
  1. The child turns age 26.
  2. Coverage for the grandchild ends when your child (parent of grandchild) ceases to be an eligible dependent or becomes age 18, whichever occurs first. The grandchild is then eligible for continuation coverage.
  3. Coverage for a spouse and stepchildren under your plan terminates when there is an entry of judgment of divorce.
  4. Coverage for a domestic partner and children of your domestic partner terminates when the *Affidavit of Termination of Domestic Partnership* (ET-2372) is filed.
  5. The child was covered per Wis. Stat. § 632.885 (2) (b) and ceases to be a full-time student.
  6. The child becomes insured as an employee of a state agency, or an employer who participates in the State of Wisconsin Group Health Insurance Program.

You may terminate coverage for your adult dependent within 30 days of their eligibility for and enrollment in another group health insurance program. Termination will be effective the first of the month following receipt of an electronic or paper application. You may also terminate coverage for your adult dependent during the annual It's Your Choice enrollment period to be effective January 1 of the following year.

See Continuation of Health Coverage for information on continuing coverage after eligibility terminates.

Family Status Changes

7. Which changes need to be reported?

You need to file an electronic or paper application as notification for the following changes to your benefits/payroll/personnel office within 30 days of the change. Annuitants and continuants will need to contact ETF. Additional information may be required. Failure to report changes on time may result in loss of benefits or delay payment of claims.

- Change of name, address, telephone number and Social Security number, etc.
- Obtaining or losing other health insurance coverage
- Addition of a dependent (within 60 days of birth, adoption or date legal guardianship is granted)
- Loss of dependent's eligibility
- Marriage/domestic partnership
- Divorce/termination of a domestic partnership
- Death (Contact ETF if dependent is your named survivor.)
- Eligibility/Enrollment for Medicare

8. Who do I notify when a dependent loses eligibility for coverage?

You have the responsibility to inform your employer (ETF for annuitants and continuants) of any dependents losing eligibility for coverage under the Wisconsin Public Employers Group Health Insurance Program. Under federal law, if notification is not made within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, the right to continuation coverage is lost. A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

If your last dependent is losing eligibility, you must file an application to change to single coverage.

9. What action do I need to take for the following personal events (marriage, domestic partnership, birth, etc.)? What restrictions apply?

Marriage
You can change from single to family coverage to include your spouse (and stepchildren if applicable) without restriction, provided your electronic or paper application is received within 30 days after your marriage, with family coverage being effective on the date of your marriage.

If you were enrolled in family coverage before your marriage, you need to complete an electronic or paper application as soon as possible to report your change in marital status, add your new spouse (and stepchildren) to the coverage, and if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of marriage. (See Question: What if my spouse/domestic partner and I work for the same employer?)

Note: You may also change health plans when adding a dependent due to marriage. The subscriber will need to file an application within 30 days of the marriage with coverage effective with the new plan on the first day of the month on or following receipt of the application.

Domestic Partnership
You can change from single to family coverage to include your eligible domestic partner (and his/her eligible children if applicable) when you submit an *Affidavit of Domestic Partnership* (ET-2371) to ETF with a copy of it and an application, either electronically or via paper. Active employees should submit the application to your employer, and annuitants should submit it to ETF, within 30 days of the date ETF receives a completed *Affidavit of Domestic Partnership* (ET-2371). Coverage will be effective on the day ETF receives the completed *Affidavit of Domestic Partnership* (ET-2371).

If you were enrolled in family coverage before your domestic partnership, you need to complete an *Affidavit of Domestic Partnership* (ET-2371) and an electronic or paper application as soon as possible to report your change in status and add your new domestic partner (and his/her eligible children) to the coverage. (See Question: What if my spouse/domestic partner and I work for the same employer?)

Birth/Adoption/Legal Guardianship/Dependent Becoming Eligible
If you already have family coverage, you need to submit a timely electronic or paper application to add the new dependent. Coverage is effective from the date of birth, adoption or the first of the month following the granting of legal guardianship, or when a dependent becomes eligible and otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity or other information as requested by your employer.

If you have single coverage, you can change to family coverage with your current health plan by submitting an application within 30 days of the date a dependent becomes eligible or within 60 days of birth, adoption or the date legal guardianship is granted.

Note: You may also change health plans if you, the subscriber, file an application within 30 days of a birth or adoption with coverage effective on the first day of the month on or following receipt of the application.

Single Mother or Father Establishing Paternity
A subscriber may cover his or her dependent child, effective with the child's birth or adoption, by submitting a timely application, either electronically or via paper, changing from single to family coverage.

Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the "Voluntary Paternity Acknowledgment" (form HCF 5024) is filed with the Department of Health Services (or equivalent if the birth was outside the state of Wisconsin), or the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. If more than 60 days after the birth, coverage is effective on the first of the month following receipt of the application.

A single mother may cover the child under her health plan effective with the birth by submitting an application changing from single to family coverage.

Upon Order of a Federal Court Under a National Medical Support Notice
This can occur when a parent has been ordered to insure his/her eligible child(ren) who are not currently covered. You will need to submit an electronic or paper application to your benefits/payroll/personnel office with coverage becoming effective on either:

- The first of the month following receipt of application by the employer; or
- The date specified on the National Medical Support Notice.

Divorce
Your ex-spouse (and stepchildren) can remain covered under your family plan only until the end of the month in which the marriage is terminated by divorce or annulment, or to the end of the month in which the Continuation-Conversion Notice (ET-2311) is provided to the divorced spouse, if family premium continued to be paid, whichever is later. (In Wisconsin, a legal separation is unlike divorce in that it does not affect coverage under the Wisconsin Public Employers Group Health Insurance Program.) The entry of judgement of divorce is usually when the judge signs the divorce papers and the clerk of courts date stamps them. You should notify your payroll office prior to the divorce hearing date and once the entry of judgment of divorce has occurred. You will need to contact the clerk of courts to learn the date

of entry of judgment of divorce. If you fail to provide timely notice of divorce, you may be responsible for premiums paid in error which covered your ineligible ex-spouse and stepchildren. Your ex-spouse and stepchildren are then eligible to continue coverage under a separate contract with the group plan for up to 36 additional months. Conversion coverage would then be available. You can keep your dependent children and adopted stepchildren on your family plan for as long as they are eligible (age, student status, etc.). (See Continuation of Health Coverage.)

You must file an electronic or paper health application with your employer to change from family to single coverage or to remove ineligible dependents from a family contract.

When both parties in the divorce are employees or annuitants, and each party is eligible for this health insurance in his or her own right and is insured under this program at the time of the divorce, each retains the right to continue this health insurance coverage, regardless of the divorce (unless the employer withdraws from this program).

The participant who is the subscriber of the insurance coverage at the time of the divorce must submit an electronic or paper health application to remove the ex-spouse from his or her coverage and may also elect to change to single coverage.

The participant insured as a dependent under his or her ex-spouse's insurance must submit a health application to establish coverage in his or her own name. The ex-spouse must continue coverage with the same plan unless he or she moves out of the service area (e.g., county). The electronic or paper application must be received by the employee's benefits/payroll/personnel office (or ETF, for annuitants) within 30 days of the date of the divorce.

Each participant may cover any eligible dependent children (not former stepchildren) under a family contract. Coverage of the same dependents by both parents would be subject to Coordination of Benefits provisions. Refer to Uniform Benefits in the *It's Your Choice 2015 Reference Guide* (your plan benefit certificate) or contact your health plan directly for information on Coordination of Benefits policies and procedures.

Note for active employees: Failure to apply in a timely manner will limit enrollment to the annual It's Your Choice Open Enrollment period for January 1, coverage.

Note for annuitants: If you fail to enroll within 30 days of the date of divorce, you have no enrollment or continuation rights. (See Question: Are there other enrollment opportunities available to me after my initial one expires?)

Termination of a Domestic Partnership

Your former domestic partner (and eligible children of a domestic partnership) can remain covered under your family plan only until the end of the month in which ETF receives your *Affidavit of Termination of Domestic Partnership* (ET-2372). If you fail to provide timely notice of termination of the domestic partnership, you may be responsible for premiums paid in error that covered your former domestic partner and children of a domestic partnership. After termination, your ex-domestic partner and ineligible children of the domestic partnership are then eligible to continue coverage under a separate contract with the group plan for up to 36 additional months. Conversion coverage would then be available. You can keep your dependent children and adopted children/stepchildren on your family plan for as long as they are eligible (age, student status, etc.). (See the Continuation of Health Coverage Section for more information.)

When both parties in the domestic partnership are employees or annuitants, and each party is eligible for this health insurance in his or her own right and is insured under this program at the

time of the termination, each retains the right to continue this health insurance coverage (unless the employer withdraws from this program). Upon termination of a domestic partnership, an affidavit must also be filed, in addition to an electronic or paper application.

The participant insured as a dependent under his or her former domestic partner's insurance must submit an electronic or paper application to establish coverage in his or her own name. The former domestic partner must continue coverage with the same plan unless he or she moves out of the service area (e.g., county). The application must be received by his or her benefits/payroll/personnel office within 30 days of ETF receiving the *Affidavit of Termination of the Domestic Partnership* (ET-2372).

Each participant may cover any eligible dependent children (not former dependents who lost coverage due to a terminated domestic partnership) under a family contract. Coverage of the same dependents by both parents would be subject to Coordination of Benefits provisions. Refer to the Uniform Benefits (your plan's benefit certificate) in the *It's Your Choice 2015 Reference Guide* or contact your health plan directly for information on Coordination of Benefits policies and procedures.

Note for active employees: Failure to apply in a timely manner will limit enrollment to the annual It's Your Choice Open Enrollment period for January 1, coverage.

Note for annuitants: If you fail to enroll within 30 days of the date of divorce, you have no enrollment or continuation rights. (See Question: Are there other enrollment opportunities available to me after my initial one expires?)

Medicare Eligibility
Please refer to the Medicare information in this reference guide for details regarding Medicare eligibility and enrollment requirements.

Death
Surviving Dependents. If an active or retired employee with family coverage dies, the surviving insured dependents shall have the right to continue coverage for life under the Wisconsin Public Employers Group Health Insurance Program at group rates as long as the former employer continues to participate in the program. The dependent children may continue coverage until eligibility ceases if they:

- Were enrolled at the time of death; or
- Were previously insured and regain eligibility; or
- Are a child of the employee and born after the death of the employee.

Health insurance coverage will automatically continue for your covered surviving dependents. Continued coverage will be effective on the first of the month after your date of death or final deduction of your active employee premium. Surviving dependents may voluntarily terminate coverage by providing written notification to ETF and coverage will terminate on the last day of the month in which their written request is received by ETF.

If the surviving dependent(s) terminates coverage for any reason he or she may not re-enroll later.

Note: The survivors may not add persons to the policy who were not insured at the time of death.

If single coverage was in force at the time of death, the full monthly premiums collected for coverage months following the date of death will be refunded. No partial month's premium is refunded for the month of coverage in which the death occurred. Surviving dependents are not

eligible for coverage.

10. When can I change from family to single coverage or single to family coverage?

If your employee premiums are deducted on a pre-tax basis under Internal Revenue Code Section 125, switching from family to single coverage is not allowable unless there is an IRS qualified family status change such as divorce, marriage, birth or adoption. For example, all covered family members lose eligibility for health coverage or become eligible for and enroll in another group plan. However, you must check this with your employer or your Section 125 plan administrator. If any covered dependents remain eligible for coverage, a change from family to single coverage is allowed only during the It's Your Choice Open Enrollment period.

If your premiums are deducted on a post-tax basis, you may change from family to single coverage at anytime. The change will be effective on the first day of the month on or following receipt of your electronic or paper application by your benefits/payroll/personnel office (ETF for annuitants and continuants). Switching from family to single coverage when you still have eligible dependents is deemed a voluntary cancellation of coverage for all covered dependents and is not considered a "qualifying event" for continuation coverage.

Changing from single to family coverage, regardless of whether your premiums are deducted on a pre- or post-tax basis, is only allowed during the It's Your Choice enrollment period, or when you or an eligible dependent has a qualifying event that allows for family coverage. See the Frequently Asked Question, "If I do not change from single to family coverage during the It's Your Choice Open Enrollment period, will I have other opportunities to do so?" in the *It's Your Choice 2015 Decision Guide*.

Benefits and Services

Health Plan Information

1. When and how must I notify my health plan of various changes?

All changes in coverage are accomplished by completing an approved electronic or paper application within 30 days after the change occurs. Always file an application through your benefits/payroll/personnel office to notify your plan of changes. Failure to report changes on time may result in loss of benefits or delay payment of claims. (See Question: Which family changes need to be reported?):

- Change in plan (for example, from HMO to Standard Plan)
- Change in plan coverage (for example, from single to family)
- Name change
- Change of address or telephone number
- Addition/deletion of a dependent to an existing family plan

Exception: Some health plans require you to notify them if you change your primary care physician. Contact your health plan for details.

2. How do I receive health care benefits and services?

You will receive identification cards from the plan you select. If you lose these cards or need additional cards for other family members, you may request them directly from the plan. Alternate plans (health plans that offer Uniform Benefits for medical coverage) are not required to provide you with a certificate describing your benefits. The Uniform Benefits section in the *It's Your Choice 2015 Reference Guide* provides this information and will serve as your certificate.

Present your identification card to the hospital or physician who is providing the service. Identification numbers are necessary for any claim to be processed or service provided.

Most of the alternate plans also require that non-emergency hospitalizations be prior authorized and contact be made if there is an emergency admission. Prior authorizations are required for high-tech radiology (for example, MRI, PET, CT scans) and for low back surgeries. Check with your plan, and make sure you understand any requirements.

For the Standard Plan and SMP, it is recommended or required that you or your physician contact the health plan before you are admitted to a hospital unless it is an emergency. In an emergency, you must notify the plan within two business days of the admission or as soon as reasonably possible.

3. Will an HMO cover dependent children who are living away from home?

Only if the HMO has providers in the community in which the child resides. Emergency or urgent care services are covered wherever they occur. However, non-emergency treatment must be received at a facility approved by the plan. Outpatient mental health services and treatment of alcohol or drug abuse may be covered. Refer to the Uniform Benefits in the *It's*

Your Choice 2015 Refernce Guide. Contact your health plan for more information.

4. How do I file claims?

Most of the services provided by health plans do not require filing of claim forms. However, you may be required to file claims for some items or services. The Standard Plan, Medicare Plus and SMP require claims incurred in any calendar year to be received by the administrator no later than the end of the next calendar year. Alternate Plans (health plans that offer Uniform Benefits for medical coverage) require claims be filed within 12 months of the date of service or, if later, as soon as reasonably possible.

5. How are my benefits coordinated with other health insurance coverage?

When you are covered under two or more group health insurance policies at the same time and both contain coordination of benefit provisions, insurance regulations require the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first; then the secondary carrier would consider the remaining expenses. (See the Coordination of Benefits Provision found in the Uniform Benefits Section of the *It's Your Choice 2015 Reference Guide*.) Note that with coordination of benefits, the secondary carrier may not always cover all of your expenses that were not covered by the primary carrier.

Provider Information

6. Does an HMO cover care from physicians who are not affiliated with the plan?

Most HMO plans will pay nothing when non-emergency treatment is provided by physicians outside of the plan unless there is an authorized referral. Contact the plans directly regarding their policies on referrals.

For emergency or urgent care, plans are required to pay for care received outside of the network, but it may be subject to usual and customary charges. This means the plan may not pay the entire bill and try to negotiate lower fees. However, ultimately the plan must hold you harmless from collection efforts by the provider. (See the Uniform Benefits definition of Emergency Care in the *It's Your Choice 2015 Reference Guide*.)

7. How do I choose a primary physician or pharmacy that is right for me?

If you're not sure a provider holds the same beliefs as you do, call the clinic or pharmacy and ask about your concerns. For example, you may want to ask about the provider's opinion about dispensing a prescription for oral contraceptives.

8. How do I know which providers are in-network providers?

See the plan description page in the *It's Your Choice 2015 Decision Guide* for more information on how to access or receive a provider directory. You may also contact the health plan administrator to receive a printed copy. Neither ETF nor your employer maintain a current

list of this information.

9. Can I change primary physicians within my alternate health plan?

Alternate plans (health plans that offer Uniform Benefits for medical coverage) differ in their policies. Contact your health plan to find out their requirements to make this change and when your change will become effective.

10. If my physician or other health care professional is listed with an alternate health plan, can I continue seeing him or her if I enroll in that alternate health plan?

If you want to continue seeing a particular physician (or psychologist, dentist, optometrist, etc.), contact that physician to see which HMO, if any, he or she is affiliated with and if he or she will be available to you under that HMO. Confirm this with the HMO. Even though your current physician may join an HMO, he or she may not be available as your primary physician just because you join that HMO.

11. What happens if my provider leaves the plan midyear?

Health care providers appearing in any published health plan provider listing or directory remain available for the entire calendar year except in cases of normal attrition (that is, death, retirement or relocation) or termination due to formal disciplinary action. A participant who is in her second or third trimester of pregnancy may continue to have access to her provider until the completion of postpartum care for herself and the infant.

If a provider contract terminates during the year (excluding normal attrition or formal disciplinary action), the plan is required to pay charges for covered services from these providers on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the member is held harmless. Health plans will individually notify members of terminating providers (prior to the It's Your Choice Open Enrollment period) and will allow them an opportunity to select another provider within the plan's network.

Your provider leaving the plan does not give you an opportunity to change plans midyear.

12. What if I need medical care that my primary physician cannot provide?

As an HMO or SMP participant, you are strongly recommended to designate a primary physician or clinic. Your primary physician is responsible for managing your health care. Under most circumstances, he or she may refer you to other medical specialists within the HMO's or SMP's provider network as he or she feels is appropriate. However, referrals outside of the network are strictly regulated. Check with your health plan for their referral requirements and procedures.

In case of an injury that may fall under workers' compensation, you should utilize only providers in your health plan, in case workers' compensation denies your claim.

Premium Contribution Tiering

13. How are health premium contributions determined?

Employers determine the amount they will contribute toward the premium under one of the two methods described here.

1. Your employer pays between 50% and 88% of the premium rate of the average cost qualified plan in the employer's service area for either single or family coverage for employees who are participants under the WRS.

   Your employer may pay as little as 25% of the premium for either single or family coverage for an employee appointed to a position working less than 1,044 hours per year and who is a participating employee under the WRS.

2. A three-tier health insurance premium option is available. Each health plan is assigned to one of three tiers based on the quality of care and relative efficiency with which it provides benefits. Health plans providing the most cost-effective, quality care (as determined by ETF) are assigned to Tier 1, moderately cost-effective plans to Tier 2 and the least cost-effective plans to Tier 3.

   The employee's required contribution to the health insurance premium for coverage is the same dollar amount for all health plans in the same tier, regardless of the total premium.

Note: Your employer may contribute any amount toward the premium for retired employees who continue group coverage.

14. Does a health plan with a higher premium or a higher tier offer more benefits?

No; all alternate plans (HMOs, WEA Trust) are required to offer the Uniform Medical Benefits. Premium rates and tier placement may vary because of many factors: how efficiently the health plan is able to provide services and process benefit payments; the fees charged in the area in which service is being rendered; the manner in which the health care providers deliver care and are compensated within the service area; and how frequently individuals covered by the health plan use the health plan. Also, health plans offering optional dental coverage may have slightly higher premiums. The Standard Plan and Medicare Plus will continue to offer benefits that differ from Uniform Benefits.

15. How often will premium rates change?

All group premium rates change at the same time: January 1 of each year. The monthly cost of all health plans will be announced during the It's Your Choice Open Enrollment period.

16. How do I pay my portion of the premium?

Active Employees: Premiums are paid in advance. Therefore, initial deductions from your salary probably will occur about one month or more before coverage begins. If the initial deduction cannot occur that far in advance, then double deductions may be required initially so as to make premium payments current.

Retired Employees: Premium rates for retired employees are the same as for active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). The employer may, at its option, pay a portion or all of the premium. If you are paying your entire premium, it will be deducted from your monthly annuity. If the annuity is not sufficient to allow a premium deduction, you will be billed directly from your health plan. *Warning*: Your coverage will be cancelled if you fail to pay your premium in a timely manner.

If you are retired and have life insurance coverage through the Wisconsin Public Employers Group Life Insurance Program, you may be eligible to convert the present value of your life insurance to pay health insurance premiums. You must be at least age 67, or age 66 if your employer provides post-retirement life insurance coverage at the 50% level. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. You will *not* receive any direct cash payment. You may file the election at anytime, and it will be effective no earlier than 61 days after ETF receives it. For more information and an election form, contact ETF.

Pharmacy Benefit Manager (PBM)

1. What is a Pharmacy Benefit Manager (PBM)?

A PBM is a third-party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, it typically negotiates discounts and rebates with drug manufacturers, contracts with pharmacies and develops and maintains the drug formulary. The Wisconsin Public Employers Group Health Insurance Program's PBM uses a fully transparent business model which means they negotiate rebates and discounts on behalf of the Wisconsin Public Employers Group Health Insurance Program and pass the savings directly back to the program.

2. What is a formulary? How is it developed? How will I know if my prescription drug is on it?

A formulary, which is established by a committee of physicians and pharmacists, is a list of prescription drugs that are determined to be both medically effective and cost-effective. The formulary is developed by the PBM's Pharmacy and Therapeutics Committee, which includes a statewide group of physicians and pharmacists. Drugs are evaluated on the basis of effectiveness, side-effects, drug interactions and then cost. New drugs are reviewed on a continuous basis to make sure the formulary is kept up-to-date and that patient needs are being met.

The complete formulary can be found on Navitus' website, www.navitus.com through Navi-Gate for Members. Just click on Members - Your Formulary under the "Quick Links" section to login, and then select the formulary named "State of WI and WI Public Employers (administered through ETF) Formulary." You may also call Navitus Customer Care toll free at 1-866-333-2757 with questions about the formulary.

3. How does a four-level drug copayment system work?

Under a four-level prescription drug benefit, you have four different copayment amounts for covered prescription drugs. By having to pay a lower copayment for Level 1 and Level 2 drugs, you are encouraged to use the preferred formulary drugs. Drugs that are listed on the formulary at the Level 3 copayment are considered non-formulary drugs but are still covered if you wish to use them and pay the higher copayment. This gives you more freedom of choice with the drugs that you are prescribed. Level 4 drugs are Specialty Medications that have the highest copayment and are also classified as either formulary or non-formulary drugs. Formulary Specialty Medications may have a reduced copayment if the prescription is filled at the preferred participating pharmacy for Specialty Medications (Diplomat Specialty Pharmacy). The copayments for Level 1 and Level 2 (formulary) drugs are applied to your annual Level 1/Level 2 out-of-pocket limit (OOPL). The copayments for formulary Specialty Medications are applied to your Level 4 OOPL, which is separate from the Level 1/Level 2 OOPL. The copayment for Level 3 drugs and non-formulary Specialty Medications do not count towards any OOPL.

Under the four-level prescription drug benefit, it may still be necessary to get a prior authorization before some formulary and non-formulary drugs will be covered.

4. How does the prescription drug benefit work for the Level 4 copay for specialty and certain other medications?

Formulary and non-formulary prescription drugs that are classified by Navitus as specialty medications have a Level 4 copayment of $50 when they are filled at a participating network pharmacy. The $50 copayment for formulary specialty drugs counts toward your $1,000/$2,000 Level 4 out-of-pocket limit (OOPL). Copayments for non-formulary specialty drugs do not count toward the Level 4 OOPL.

We strongly encourage you to participate in the Navitus SpecialtyRx, specialty pharmacy program. If you have your prescriptions for specialty drugs filled at the preferred participating pharmacy for specialty medications, which is currently Diplomat Specialty Pharmacy, you will have a reduced copayment of $15 for formulary specialty drugs (which also counts toward the Level 4 OOPL). These drugs will be marked with "ESP" on the formulary. This also allows you to take advantage of the additional, personalized services available with the Navitus SpecialtyRx, specialty pharmacy program. Non-formulary specialty and certain other drugs are not eligible for the reduced copayment, and the copayments do not count toward the Level 4 OOPL.

To enroll in the Navitus SpecialtyRx, specialty pharmacy program or to obtain additional information, call 1-877-651-4943 or visit diplomatpharmacy.com.

5. Will I have to use a different ID card when I go to the pharmacy?

Yes, you will have two identification cards, one from your health plan and one from either (a) Navitus Health Solutions or (b) the Navitus MedicareRx (PDP) plan (for eligible retirees enrolled in Medicare) for pharmacy benefits. Your member identification number will be different on each card, so it is important that you show the correct card when getting services. When filling prescriptions, you must present your pharmacy benefits ID card to the pharmacist.

Medicare Information

For information about Medicare benefits, eligibility and how to enroll, contact your local Social Security Administration office or call 1-800-772-1213. In addition, the State Health Insurance Assistance Program (SHIP) has counselors in every state and several territories who are available to provide free one-on-one help with your Medicare questions or problems. The Wisconsin SHIP can be reached at 1-800-242-1060. Additional information and assistance can be found at http://www.dhs.wisconsin.gov/benefit-specialists/ship.htm . A list of SHIP programs outside of Wisconsin can be found at www.medicare.gov/contacts/staticpages/ships.aspx.

Because all health plans that participate in the Wisconsin Public Employers Group Health Insurance Program have coverage options that are coordinated with Medicare, you will remain covered by the health plan you have selected even after you enroll in Medicare. Premium rates will decrease if Medicare covers you or a dependent, and you are retired. Medical and prescription drug coverage under the Alternate Plans (health plans that offer Uniform Benefits for medical coverage) does not change. The health plan will simply not duplicate benefits paid by Medicare. However, if enrolled in the Standard Plan or SMP, your coverage will change to Medicare Plus when you enroll in Medicare Parts A and B.

If you are not enrolled for all available portions of Medicare (A, B and D) upon retirement, you may be liable for the portion of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.

The following questions and answers provide additional information about Medicare as it applies to the Wisconsin Public Employers Group Health Insurance Program.

1. What do I need to do when my spouse/domestic partner or I become eligible for Medicare?

Important: When you receive your Medicare card, please send a photocopy to ETF immediately or your Medicare coordinated coverage may be delayed.

You and your dependents are not required to enroll in Medicare until you, as the subscriber, terminate employment or health insurance coverage as an active employee ceases. At the time of your retirement, you and your dependents who are eligible for Medicare must enroll for the Part A (hospital) portion and Part B (medical) portion of Medicare. When you and/or your dependents enroll in Medicare Parts A and B, your group health insurance coverage will be integrated with Medicare and the monthly premium will be reduced.

In general, enrollment in Medicare Part D (prescription drug coverage) is voluntary; however, you may pay a penalty if you do not enroll when you are first eligible or are not covered by what Medicare considers creditable coverage. Regardless, Medicare Part D coverage is provided by the Wisconsin Public Employers (WPE) group health insurance program. Additional information about all parts of Medicare can be found in the following questions and answers.

If you become eligible for Medicare, your eligibility for COBRA coverage ends. Contact ETF for more information.

2. When must I apply for Medicare?

Medicare Part A
Most people become eligible for Medicare upon reaching age 65. Individuals who have been determined to be disabled by the Social Security Administration (SSA), become eligible after a 24-month waiting period.

- If you or your spouse/domestic partner are actively working when you become eligible, you may want to consider enrolling in Medicare Part A, as it may cover hospital services if your health plan denies them. There is no premium for Medicare Part A.

Medicare Part B
The requirement to enroll in Medicare Part B coverage is deferred for active employees and their dependents until the subscriber's termination of their WRS-covered employment, through which active employee health insurance coverage is provided.

If you have terminated employment, or are a surviving dependent, or a continuant and are eligible for coverage under the federal Medicare program, you must immediately enroll in both Part A and Part B of Medicare unless you are otherwise employed and have health insurance coverage through that employment. If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portions of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.

If you or your insured spouse/domestic partner is employed by an employer that does not participate in the WPE group health insurance program, and has coverage as an active employee under that employer's group plan, enrollment in Medicare may be deferred until retirement from that job.

For subscribers and their dependents with End Stage Renal Disease (ESRD): You will want to contact your local Social Security office, health plan, provider and Medicare to make sure you enroll in Medicare Part A and Part B at the appropriate time. The Wisconsin Public Employers Group Health Insurance Program will provide primary coverage during the 30-month coordination period for members with ESRD. You will want to decide if it would be beneficial to enroll in Part B during your initial or general enrollment opportunities to avoid later delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends.

Medicare Part D
U.S. resident retired members and their spouses, domestic partners and/or dependents who are Medicare enrolled and who participate in the Wisconsin Public Employers Group Health Insurance Program will automatically be enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified medicare contracting prescription drug plan. The prescription drug coverage under this program is Medicare Part D coverage. Your monthly health insurance premium includes a portion that applies to this program's coverage.

Before Navitus can report your enrollment in Part D to Medicare, they need to have your Medicare Health Insurance Claim (HIC) number and Parts A and B effective dates. In most cases, ETF will request this information from you two to three months in advance of your 65th birthday by sending you a *Medicare Eligibility Statement* (ET-4307). ETF will then provide the information to Navitus. Please complete and return this form as soon as possible to ensure you receive the benefits you are eligible for and your claims are paid properly.

If you do not receive the *Medicare Eligibility Statement* (ET-4307) at least one month before your 65th birthday please contact ETF. If you are retired and cover a Medicare-eligible spouse or disabled dependent on your health plan, please notify ETF and provide your dependent's

Medicare information.

Individuals may choose to enroll in another Medicare Part D prescription drug plan; however, it is not recommended or required for your continued coverage under the Wisconsin Public Employers (WPE) group health insurance program. If you choose to enroll in a different Medicare Part D plan, your health insurance premium for the WPE plan does not change, but your ETF pharmacy coverage will be secondary to the other Medicare Part D plan. For more information, see Question: Does Medicare Part D affect my prescription drug coverage? Should I enroll? and Question: Will my health insurance premium go down if I enroll in a Medicare Part D prescription drug plan?

3. If Medicare coverage is in effect, how do I file Medical, Part B and Pharmacy claims?

If Medicare is the primary insurance, your provider must submit claims to Medicare first. Once Medicare processes the claim(s), Medicare will send you a quarterly Medicare Summary Notice (MSN).

Alternate Plans (health plans that offer Uniform Benefits for medical coverage):
Many of the health plans have an automated procedure after Medicare processes the claim, where the provider then submits it to the health plan for processing. However, some health plans require members to submit a copy of the MSN and, in certain circumstances, a copy of the provider's bill. You should discuss with your provider if they will bill Medicare and your health plan on your behalf. Contact your health plan for additional information.

Alternate Medicare Advantage Preferred Provider Organization (MA-PPO):
An alternate health plan may offer Medicare coordinated coverage through a MA-PPO. When you visit your provider, you must show your health plan's MA-PPO card. Your provider will submit your claims directly to the MA-PPO. To request reimbursement for a covered service charge that you paid, send your receipt (noting on it your name and your MA-PPO member ID) and a copy or your MA-PPO card to the address on the back of that card.

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PPO. You should keep your Medicare card in a safe place, but you should not show it when you receive health care services, as the MA-PPO will be primary for your service. (See Question: If I have Medicare as my primary coverage, how are my benefits coordinated?) Humana currently offers this type of MA-PPO.

Pharmacy Benefit Manager:
As long as you maintain the Navitus MedicareRx (PDP) plan as your Medicare Part D PDP, Navitus will process your claims for both Part D and the supplemental wrap coverage that is included.

However, if you choose to enroll in a Medicare Part D plan other than the Navitus MedicareRx (PDP) plan, your supplemental wrap coverage, which is part of the WPE group health insurance program pharmacy benefits, will be considered secondary. Some, but not all, network pharmacies may be able to process the secondary claims electronically. However, you should be prepared to file the secondary claims manually through Navitus. Contact Navitus for more information on filing manual claims. Refer to the Medicare Part D Information section of the FAQs for more details.

Medicare Part B pharmacy claims are covered under the supplemental wrap benefit. For specific information on Medicare Part B pharmacy coverage and Part B claims processing,

see the plan description page for Navitus™ Health Solutions in the *It's Your Choice 2015 Decision Guide*.

4. If I have Medicare as my primary coverage, how are my benefits coordinated?

Since all health plans have coverage options that are coordinated with Medicare, you will remain covered by the health plan you selected after you are enrolled in Medicare, even though Medicare is the primary payor of your claims.

Exception: If you are enrolled in the Standard Plan or SMP, your coverage will be changed to Medicare Plus. There are some differences in benefits between these health plans. Medicare Plus is designed to supplement the benefits you receive under Medicare. For purposes of paying benefits, Medicare is the primary plan and Medicare Plus is the secondary plan. This means Medicare reviews claims first and determines what, if anything, should be paid and then the Medicare Plus plan reviews the claims to determine if there is anything else that is payable.

If you are enrolled in an alternate plan (health plans that offer Uniform Benefits for medical coverage), your health coverage will remain substantially the same as before Medicare coverage became effective. For purposes of paying benefits, Medicare is the primary plan and the state health plans are the secondary plan. This means Medicare reviews claims first and determines what, if anything, should be paid and then the state health plans review the claims to determine if there is anything else that is payable. Because of this coordination with Medicare, your monthly premiums for your Wisconsin Public Employers Group Health Insurance Program will be less. *Note*: For some benefits under Uniform Benefits, such as durable medical equipment, Medicare Part B and the health plan both have a 20% coinsurance that you are responsible to pay.

5. What is Humana's Medicare Advantage Plan?

Humana offers Medicare Coordination Coverage through a Medicare Advantage Preferred Provider Organization (MA-PPO). As Medicare has contracted financial responsibility for medical benefit administration to this MA-PPO plan, all claims should be submitted to the MA-PPO. You must keep Medicare Part A and B coverage, but you will not need to show your Medicare card to your providers, instead show your MA-PPO card. Members who are direct billed by Humana will receive two bills that will add up to the total amount due. Both bills must be paid monthly for coverage to continue.

This MA-PPO plan offers greater flexibility in provider selection than a traditional HMO for retirees over age 65 and on Medicare. For members under age 65 who are not on Medicare, you must comply with the health plan's network requirements.

If you are enrolled in MA-PPO, have Medicare Part A and B, and are no longer an active employee, your benefits will be modeled on Uniform Benefits and include those of traditional Medicare. You have the freedom to choose providers. However, you will have greater out-of-pocket costs if you use out-of-network providers. Contact the MA-PPO for provider information.

6. What is the Social Security Income-Related Monthly Adjusted Amount (IRMAA) and does it affect me?

If you are enrolled in Medicare and your modified adjusted gross income exceeds certain limits established by federal law, you may be required to pay an adjustment to your monthly Medicare Part B (medical) and Medicare Part D (prescription drug) coverage premiums. The additional premium amount you will pay for Medicare Part B and Medicare prescription drug coverage is called the income-related monthly adjustment amount or IRMAA. Since Medicare beneficiaries enrolled in the Wisconsin Public Employers Group Health Insurance Program are required to have Medicare Parts A, B and D, the IRMAA may impact you if you have higher income.

To determine if you will pay the additional premiums, Social Security uses the most recent federal tax return that the IRS provides and reviews your modified adjusted gross income. Your modified adjusted gross income is the total of your adjusted gross income and tax-exempt interest income.

Social Security notifies you in November about any additional premium amounts that will be due for coverage in the next year because of the IRMAA. You must pay the additional premium amount, which will be deducted from your Social Security check if it's large enough. Failure to pay may result in Medicare terminating your coverage. The IRMAA is paid to Social Security, not the Wisconsin Public Employers Group Health Insurance Program. It is not included in your Wisconsin Public Employers Group Health Insurance Program premium.

Additional information can be found in SSA Publication No. 05-10536 or by calling the SSA toll-free at 1-800-772-1213.

Medicare Part D Information

7. Which Medicare Part D prescription drug coverage is provided under the Wisconsin Public Employers (WPE) Group Health Insurance Program?

Medicare related prescription drug coverage will be provided by Navitus Health Solutions (Navitus) through a self-funded, Medicare Part D Employer Group Waiver Plan (EGWP) called the Navitus MedicareRx (PDP) plan underwritten by Dean Health Insurance Inc. This affects Medicare-eligible participants covered under an annuitant contract enrolled in the WPE Group Health Insurance Program. As required by Uniform Benefits, a supplemental wrap benefit is also included to mainly provide full coverage to WPE members when they reach the Medicare coverage gap, also known as the "donut hole." But the supplemental wrap benefit will also provide coverage at other times when the EGWP does not, such as during the Medicare Part D deductible and the initial coverage phases. Dean has been contracted with the Centers for Medicare and Medicaid Services since 2006, when Medicare Part D was first implemented to offer Medicare Part D prescription drug plans to employer groups.

Your group health insurance premium already includes the cost of this benefit. There is no separate premium that needs to be paid for this Medicare Part D coverage. It is important that you read and understand the information presented on the Navitus MedicareRx plan description page in the *It's Your Choice 2015 Decision Guide.*

8. Does Medicare Part D affect my prescription drug coverage? Should I enroll?

A Medicare Part D prescription drug plan (PDP) provides primary coverage of prescription benefits through Medicare. While enrollment in a PDP is voluntary, if you do not enroll when

you are first eligible and do not have what Medicare considers creditable coverage, you may have to pay a penalty in the form of a higher PDP premium once you do enroll.

Under the Wisconsin Public Employers Group Health Insurance Program, after you become eligible for Medicare Part D, the following will happen:

- You will be automatically enrolled in the Navitus MedicareRx (PDP) plan. Medicare eligible spouses, domestic partners and/or dependents will also be enrolled. This is Medicare Part D coverage. Your group health insurance premium already includes the costs of this Medicare Part D coverage.
- You will also be automatically enrolled for supplemental wrap coverage to ensure your prescription drugs are covered when you reach the Medicare Part D coverage gap, commonly referred to as the "donut hole." This provides you with additional benefits that "wrap around" the benefits available from your Medicare Part D coverage. Your health insurance premium already includes the cost of this supplemental wrap coverage.

When you are enrolled in the Navitus MedicareRx (PDP), plan *you will be issued a new ID card that you will be required to use*.

If you would like to maintain your current level of prescription drug benefits under our program, it is not necessary to enroll in another Medicare Part D plan. Nevertheless, participation in a Medicare Part D prescription drug plan is voluntary and you should carefully consider all options before making any kind of decision to enroll in a different Medicare Part D plan.

9. Will my health insurance premium go down if I enroll in a different Medicare Part D prescription drug plan?

No. Your health insurance premium includes both medical and prescription drug coverage. If you choose to enroll in a different Medicare Part D plan, you will be dropped from the Navitus MedicareRx (PDP) plan and you will have to pay an additional premium to the other plan you enroll in. However, you will still have secondary coverage with the supplemental wrap benefits under the WPE group health insurance program. There is no partial refund of the WPE group health insurance premium if you choose to enroll in a different PDP. Navitus will coordinate coverage with Medicare and pay secondary claims after Medicare processes your prescription claims from the other Medicare Part D plan, minus the applicable copayments and coinsurance that are your responsibility. If you enroll in another Medicare Part D plan before January 1, 2014, for coverage in 2014, and you intend to stay in that program, notify ETF immediately. If ETF enrolls you in Navitus MedicareRx, you will be automatically disenrolled from your other plan by CMS.

Dental

1. How do I find out if my health plan offers Uniform Dental Benefits in 2015?

To find out if your health plan offers the Uniform Dental Benefit, go to the Health Plan Description pages in the Choose Your Health Plan section of the *It's Your Choice 2015 Decision Guide*.

2. How do I find out which specific benefits and services are covered under the 2015 Uniform Dental Benefit?

To find out what is covered under the Uniform Dental Benefit, go to the Uniform Dental Benefit Certificate in the *It's Your Choice 2015 Reference Guide*. The Uniform Dental Benefit Certificate is your certificate of coverage. The benefits and services listed in the certificate will be covered by your health plan if your health plan offers dental coverage. No payment will be made for a benefit that is not listed in the certificate of coverage. The certificate of dental coverage also contains a number of specific exclusions and limitations. Exclusions are benefits or services that are not covered. Limitations are benefits and services that are covered but subject to specific limitations, such as visit limits or age requirements.

3. How do I find a list of dental providers offered by my health plan in 2015?

To find a list of dental providers by health plan, go to the Health Plan Description pages in the Choose Your Health Plan section of the *It's Your Choice 2015 Decision Guide*.

4. What's the benefit of having a dental plan with restricted, in-network only access?

The overall cost of using in-network dental providers is lower. Open network dental plans (where you can visit any dental provider of your choice) allow you greater choice of dental providers, but you may need to pay more out-of-pocket to access your preferred provider. Check with your health plan or dental administrator about what type of provider network is available to you.

Wellness

1. What is a biometric screening and Health Risk Assessment (HRA)?

A biometric screening is a test that measures your blood pressure, body mass index, cholesterol and glucose levels. A HRA is a questionnaire that asks about your health history and lifestyle choices. These tools help you and your doctor identify potential health risks for certain diseases and chronic conditions. The information can also help you make well-informed decisions concerning your lifestyle and healthcare options.

2. How do I complete a biometric screening and HRA?

A biometric screening can be done either at your annual physical with your Primary Care Provider (PCP) or at an onsite wellness event offered by your employer. For a schedule of onsite events, visit the Well Wisconsin website.

A HRA is available online through your health plan's website. Contact your health plan if you need help locating the webpage that contains an online HRA and biometric form. If you are unable to complete an online HRA, you may request that your health plan provide you with a paper version or that a representative from your health plan contact you to administer a HRA over the telephone

3. How do I become eligible to receive an incentive for completing a biometric screening and HRA?

You are eligible to receive a $150 incentive paid to you directly by your health plan when the health plans receives all the required documentation to show that you have completed a biometric screening and HRA. The subscriber and all adults covered under the subscriber are eligible for an incentive. At this time, annuitants with Humana Medicare Advantage coverage are not eligible.

4. When do I receive my incentive payment for completing a biometric screening and HRA?

Health plans will usually pay incentives by the end of the quarter in which you complete a biometric screening or HRA or within four weeks of the quarter ending. Contact your health plan if you have questions about the timing of incentive payments

5. Does a biometric screening and HRA have out-of-pocket costs?

No. HRAs and biometric screenings have no out-of-pocket costs when performed as preventive screenings under federal law.

6. Are the results from a biometric screening and HRA confidential?

Yes. All of the results from your biometric screening and HRA will be kept strictly confidential. Results will not be shared with your employer. Some health plans automatically send results to your PCP as part of your electronic health record; other health plans require you to request that your results be sent to your PCP. Contact your health plan for more information on how your results are sent to your PCP

7. Does my health plan offer other wellness benefits in addition to the incentive for completing a biometric screening and HRA?

Depending on your health plan, many plans will continue to offer discounts or reimbursement for fitness club memberships, community supported agriculture and health education courses for tobacco cessation, weight loss and nutrition.

8. Are health plan issued incentives taxable income?

Yes, the Internal Revenue Service considers all incentives issued to you or your enrolled adult members to be a fringe benefit of employment. Incentives are therefore subject to payroll tax. Incentive payment information will be provided to your employer at year end. The incentive will be reported as income and applicable deductions will be applied.

9. Where can I find more information about my wellness benefits?

Go to www.wellwisconsin.wi.gov to find more information on your health plan's wellness offerings, to get biometric screening and HRA forms, and to find a calendar of onsite wellness events offered by your employer.

For more information on disease management and wellness programs, see the Health Plan Features At-a-Glance section of *It's Your Choice 2015 Decision Guide*, this FAQ sections or contact your health plan.

Changing Health Plans

1. Can I change from one plan to another during the year?

Yes, but only if you, the subscriber, file an electronic or paper application within 30 days for the following events with coverage effective on the first day of the month on or following receipt of the application:

- Move from your plan's service area (for example, out of the county) for a period of at least 3 months. Your new coverage will be effective subsequent to your move. You may again change plans when you return for 3 months by submitting another application within 30 days after your return. (See Question: What if I have a temporary or permanent move from the service area?)
- You involuntarily lose eligibility for other coverage or lose the employer contribution for it.
- You add one or more dependents due to marriage, domestic partnership, birth, adoption or placement for adoption.

Note: If your premiums are being deducted post-tax, you may cancel coverage at anytime. If your premiums are being deducted on a pre-tax basis, you may cancel coverage midyear only if you become eligible for and enroll in other group coverage.

Otherwise, you can only change health plans without restriction during each It's Your Choice Open Enrollment period and coverage will be effective the following January 1.

2. If I change plans, what happens to any benefit maximums that may apply to services I've received?

When you change plans for any reason (for example, during an It's Your Choice Open Enrollment period or for a move from a plan's service area), any annual health insurance benefit maximums under Uniform Benefits (such as durable medical equipment) will start over at $0 with your new plan, even if you change plans mid-year with the exception of the prescription annual out-of-pocket maximum. Orthodontia is not part of the Uniform Benefits medical plan, but is covered under the Uniform Dental Benefit for plans that offer dental. Orthodontia lifetime benefit maximums typically carry over from one plan to the next.

3. What if I have a temporary or permanent move from the service area?

A subscriber who moves out of a service area (for example, out of the county), either permanently or temporarily for 3 months or more, will be permitted to enroll in the Standard Plan or an available alternate plan that offers in-network providers near you, provided an electronic or paper application for such plan is submitted within 30 days after relocation. You will be required to document the fact that your application is being submitted due to a change of residence out of a service area.

It is important that you submit your application to change coverage as soon as possible and no later than 30 days after the change of residence to maintain coverage for non-emergency services. The change in plans will be effective on the first day of the month on or after your application is received by your employer but not prior to the date of your move. If your

application is received after the 30-day deadline, you will not be allowed to change plans until the following It's Your Choice Open Enrollment period or in certain situations. See Question: Are there other enrollment opportunities available to me after my initial one expires?

If your relocation is temporary, you may again change plans by submitting an application within 30 days after your return. The change will be effective on the first of the month on or after your application is received by your employer or by ETF, but not prior to your return.

4. What if I change plans but am hospitalized before the date the new coverage becomes effective and am confined as an inpatient on the date the change occurs (such as January 1)?

If you are confined as an inpatient (in a hospital, a skilled nursing facility or, in some cases, an Alcohol and Other Drug Abuse (AODA) residential center) or require 24-hour home care on the effective date of coverage with the new plan, you will begin to receive benefits from your new plan unless the facility you are confined in is not in your new plan's network. If you are confined in such a facility, your claims will continue to be processed by your prior plan as provided by contract until that confinement ends and you are discharged from the non-network hospital or other facility, 12 months have passed or the contract maximum is reached. If you are transferred or discharged to another facility for continued treatment of the same or related condition, it is considered one confinement.

In all other instances, the new plan assumes liability immediately on the effective date of your coverage, such as January 1.

Cancellation or Termination of Health Coverage

1. How do I cancel coverage? How might this impact me if I later want to re-enroll?

Voluntary cancellation (or switching from family to single coverage which is deemed voluntary cancellation for all insured dependents) requires written notification to the employer (annuitants should contact ETF) and the completion of an electronic or paper application denoting a cancellation of coverage.

If your premiums are being deducted on a pre-tax basis under Internal Revenue Code Section 125, you may cancel coverage only if you are cancelling because you become eligible for and enroll in another group plan or during the annual It's Your Choice enrollment period. However, you must check this with your employer or your Section 125 plan administrator.

If your adult dependent child becomes eligible for and enrolled in other group health insurance coverage, and you want to drop coverage for him/her, you must submit an application electronically or via paper to your employer (to ETF for annuitants) within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card from that coverage. If this is your last dependent and you want to change to single coverage, you must note that on your application.

If your spouse/domestic partner becomes eligible for and enrolled in other group health insurance coverage and you want to change to single coverage or cancel your family coverage, you must submit an application electronically or via paper to your employer (to ETF for annuitants) within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card that lists all individuals covered under that plan.

If your premiums are being deducted post-tax, you may cancel at anytime. Be aware that voluntary cancellation of coverage does not provide an opportunity to continue coverage for previously covered dependents as described in the Continuation of Health Coverage section. Cancellation affects both medical and prescription drug coverage.

No refunds are made for premiums paid in advance unless your employer (or ETF if you are no longer an employee of a participating local employer) receives your written request on or before the last day of the month preceding the month for which you request the refund. Under no circumstances are partial month's premiums refunded. Once coverage terminates, you will be responsible for any claims inadvertently paid beyond your coverage effective dates.

Once an annuitant's coverage is cancelled, neither you nor your surviving dependents may re-enroll in this program. Another insurance opportunity may exist under the Local Annuitant Health Program (LAHP). Contact ETF for more information.

2. When can my health insurance coverage be terminated?

Your coverage can only be terminated because:

- Premiums are not paid by the due date. Coverage is also waived (known as "constructive waiver") when the employee portion of the premium is not deducted for 12 consecutive months.
- Coverage is voluntarily cancelled.

- Eligibility for coverage ceases (for example, termination of employment).
- Death of the subscriber.
- Fraud is committed in obtaining benefits or there is an inability to establish a physician/patient relationship. Termination of coverage for this reason requires Group Insurance Board approval.
- Employer withdraws from the Wisconsin Public Employers Group Health Insurance Program.

Contact your benefits/payroll/personnel office or ETF for the date coverage will end.

3. What if my employer's participation ends under the Wisconsin Public Employers Group Health Insurance Program?

When your employer's participation ends in this program, coverage will cease for all participants. This includes retirees, survivors and those who have continuation coverage. If the employer obtains group health insurance from another carrier, ask the employer if the new carrier will provide coverage for retirees, survivors and continuants.

When the employer terminates participation, you will not be eligible for continuation or conversion of health coverage.

Continuation of Health Coverage

1. Who is eligible for continuation?

Your COBRA continuation rights are described in the State and Federal Notification Section of the *It's Your Choice 2015 Reference Guide*. Both you and your dependents should take the time to read that section carefully. This section provides additional information about continuation coverage.

You do not have to provide evidence of insurability to enroll in continuation coverage. However, coverage is limited to the plan you had as an active employee or covered dependent. (For example, if you change plans January 1 and your dependent loses eligibility December 31, that dependent would be eligible for COBRA from the plan you were enrolled in on December 31. An exception is made when the participant resides in a county that does not include a primary physician for the subscriber's plan at the time continuation is elected. In that case, the participant may elect a different plan that is offered in the county where the participant resides.) You may select another plan during the It's Your Choice Open Enrollment period or if you move from the service area. If family coverage is in effect when continuation is first offered, each dependent may independently elect single continuation coverage. A family of two may select two single contracts at a lower cost than the premium for a family contract. The health plan will bill you directly.

There can be no lapse in coverage, so multiple premiums may be required.

A second qualifying event while on continuation will not serve to extend your period of continuation. Coverage will be limited to the original time period. At the end of the continuation period you will be allowed to enroll in an individual conversion through the health plan.

2. When my dependent loses eligibility is he/she eligible for COBRA? What do I need to do to ensure COBRA coverage is offered?

Employees need to report this change to the benefits/payroll/personnel office within 60 days of the dependent losing his/her eligibility to ensure COBRA coverage is offered. Annuitants and continuants must contact ETF. Your dependent will be entitled to 36 months of continuation coverage.

3. Does my coverage change under continuation?

No, continuation coverage is identical to the active employee coverage. In most cases, you are eligible to maintain continuation coverage for 18 months from the month of the qualifying event. These events are termination of employment or reduction in work hours. Events such as death of employee, divorce or the loss of eligibility for a dependent child entitles the dependent to 36 months of coverage. You are allowed to change plans during the annual It's Your Choice Open Enrollment period or if the subscriber moves from the service area. However, your continuation coverage may be cut short for any of the following reasons:

- The premium for your continuation coverage is not paid when due.
- You or a covered family member become covered under another group health plan that

does not have a preexisting conditions clause that applies to you or your covered family member.
- You were divorced or your domestic partnership terminated from an insured employee, and you subsequently remarry or establish a new domestic partnership and are insured through your new spouse's group health plan.
- You or a covered family member become entitled to Medicare benefits.

4. Will my premium change under continuation?

It may change as you will pay the total premium amount which includes both the employee and employer share. Contact your benefits/payroll/personnel office to obtain the total amount.

5. How do I cancel continuation coverage?

To cancel continuation coverage, notify ETF in writing. Include your name, Social Security number, date of birth and address. ETF will forward your request to the health plan. Your coverage will be cancelled at the end of the month in which ETF receives the request to cancel coverage.

6. How is my continuation coverage affected if I move from the service area?

If you move out of the service area (either permanently or temporarily for three months or more), you are eligible to change plans. (See Question: What if I have a temporary or permanent move from the service area?)

Your electronic or paper application to change plans must be postmarked within 30 days after your move. Because you are on continuation coverage, call the ETF Employer Communication Center at 608-266-5020 or go online to obtain a *Health Insurance Application/Change Form (ET-2301)*. Complete and submit the application to: Department of Employee Trust Funds, P. O. Box 7931, Madison, WI 53707-7931.

7. When is conversion coverage available?

As required by law, you are eligible to apply for conversion coverage when group continuation coverage terminates. Contact the plan directly to make application for conversion coverage. Conversion coverage is available without providing evidence of insurability and with no waiting period for preexisting conditions, provided Wisconsin Public Employers Group Health Insurance Program coverage has been in effect for at least three months prior to termination.

If the health plan automatically bills you for conversion coverage that you do not want, simply do not pay the premium for the coverage. The coverage offered will be the conversion contract (not the Wisconsin Public Employers plan) available at the time, subject to the rates and regulations then in effect. The coverage and premium amount may vary greatly from plan to plan.

If you reside outside of the HMO service area at the time you apply for conversion coverage, you may only be eligible for an out-of-area conversion policy through another insurance carrier. The benefits and rates of the out-of-area conversion plan are subject to the regulations

in effect in the state in which you reside.

The conversion privilege is also available to dependents when they cease to be eligible under the subscriber's family contract. The request for conversion must be received by the plan within 30 days after termination of group coverage. If you have questions regarding conversion, write or call the plan in which you are enrolled